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	mhl026-709	A. BUILDING: _____ B. WING _____	C 06/24/2020

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PEARL'S ANGEL CARE, INC	1423 GRANDVIEW DRIVE FAYETTEVILLE, NC 28314

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V 000	INITIAL COMMENTS A complaint survey was completed on June 24, 2020. The complaint was unsubstantiated (Intake #NC00165597). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present	V 296	RECEIVED JUL 23 2020 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Washington — TITLE: Director — (X6) DATE: 7/16/20

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V 296	Continued From page 1 of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide more than the minimum number of direct care staff based on client needs for 3 of 4 former clients (FC #1, FC #2 and FC #4). The findings are: Review on 6/15/20 of FC #1's record revealed: - 18 year old male. - Admission date 7/11/18; discharge date 5/05/20. - Diagnoses included Conduct Disorder, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, and Post-Traumatic Stress Disorder. - "Comprehensive Clinical Assessment" dated 12/09/19 included documented history of inappropriate sexual contact with younger peers, lying, manipulation, and ". . .. prohibited from returning home because there are younger	V 296	The QP will continue to monitor the consumer behaviors and increase the staff as needed to de-escalate disruptive behaviors and prevent elopement. This goal was met and confirmed to the surveyor during her interviews. The Surveyor **REFUSED** to review any supporting documents to verify I increased the staffing. I pleaded with the Surveyor during the exit interview on 6/19/20 to review and compare the timesheets, work schedules, Medication Administration Records, and Service Notes to see for herself that I worked 3 people on shift. The Surveyor refused to review the Documents. She informed me that she was giving me the Type A1 Violation and I could submit the Documents to Administration and maybe they would review the items. But she had completed her survey. I informed the Surveyor that I felt she was being Unfair and possibly Discriminating against me by not reviewing all supporting documents prior to making a Decision.	5/1/20

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V 296	Continued From page 2 female family members residing there. . . " - "Person Centered Profile" completed 6/18/19 and updated 5/05/20 included documentation of numerous elopements from the facility with law enforcement involvement; ". . . Where am I now in the process of achieving this outcome? . . . 9-17-19 . . . we can't keep him safe and secure . . . 10-18-19 . . . we need to link him to another level III because we can't keep him safe since he is AWOL (absent without leave) from school. . . " - "Safety Assessment Plan" dated 3/23/20 included ". . . Action Steps . . . [FC #1] will create an environment that reduces anxiety and Promote Safety by: (a) Intensive Supervision at all times (b) do not leave [FC #1] alone with younger children . . . (e) Monitor sexual talk between children (f) staff will process with him to prevent him from leaving the home (g) Staff will secure and monitor all exits. Staff will secure the alarms (h) Teach the importance of boundaries and the right to privacy (i) Reduce horseplay such as tickling (coercive) or wrestling (starting point for intimate behaviors, causes anxiety, guise to sexually touch other children). . . . (k) Intervene and confront child's sexually acting behavior (l) Teach "Good" touch and "Bad" Touch and secret touching . . . " - "Service Note" signed by staff #4 and dated 5/02/20 included ". . . Shift/Duration of Service: . .. 11pm - 7 am . . . Staff came into consumer at 1:15 and made a visual on him to make sure he was ok since we had another incident going on in the kitchen. At 1:30 staff observed consumer taking off and he pleading for him to come back as the other staff went searching for him. Staff had no contact with consumer on this shift . . . Consumer took of at the door at 1:30 when he thought the coast would be clear since there was an incident with another peer. Consumer had no more contact with staff on this shift."	V 296	I increased the staffing to work 3 staff on shift. I explained to the Surveyor that I worked a QP or AP Manager on each shift with the 2 direct care workers during the time frames of the elevated behaviors. As the Surveyor, has recorded in her Report on pages 3, 6, 10-11, 12, 13,14, 15 and 16 that during her Interviews with staff; they informed her that a QP or AP member of management was working shifts with the direct care workers. I feel the Surveyor's Report and her **Interviews with staff is evidence and has confirmed that I increased the staffing on shifts to 3 people and that I increased the management on shifts.** The Surveyor reported on page 13 in her Interview with staff #1 AP; informed her that 2 staff always worked shift. The incident occurred on 5/29 with 2 staff and the AP working shift. The Surveyor reported on page 14 and 15 that "staff #3 informed her during the interview that management worked shifts with 2 direct care workers".	

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V 296	Continued From page 3 - No documentation that FC #1 returned to the facility after eloping 5/02/20. - "Medication Administration Record (MAR)" for May 2020 included transcribed entries for fluoxetine (can be used to treat depression and obsessive-compulsive disorder) 20 milligrams (mg) one tablet in the morning, and risperidone (can be used to treat schizophrenia and bipolar disorder) 0.5 mg one tablet at bedtime. - "Discharge Planning/Summary Form" signed by the QP and dated 5/05/20 included " . . . Unplanned Discharge . . . Presenting Condition: Came from step down from PRTF (Psychiatric Residential Treatment Facility), inappropriate sexual behavior, verbal/physical aggressor, looking at porn, AWOL, skipping school, disrespectful . . . Reason for Discharge: [FC #1] was supposed to be discharge on 4-6-20 grandmother refused to come and get him. An DSS (Department of Social Services) referral was mad. On 5-3-20 he AWOL from group home . . . " Review on 6/01/20 of the North Carolina Incident Response Improvement System (NC IRIS) incident reports 4/28/20 - 6/01/20 for FC #1 revealed: - Level II incident report ". . . Date of Incident: 5/3/2020 Time of Incident: 1:30 AM" of ". . . Unplanned consumer absence . . . that requires police contact.. . " - ". . . Authorities contacted . . . [local police department] . . . " - "Supervisor Actions . . . Describe the cause of this incident: 5/4/20 Consumer waited in his room while his peer was causing havoc with staff. He waited until he peer took off out the house and he ran out and cut through neighbors yard. Staff went in the direction behind him but he ran in between houses and then off into the woods. Staff followed the path through woods looking for	V 296	The Surveyor reported on page 15 that she was informed by the QP on 6/4/20, 6/17/20 and 6/19/20 "that 2 Staff worked shift and sometimes 3 Staff worked shift." The Surveyor reported on page 15 and 16 during the interview with the AP/Director on 6/19/20 she was Informed that "management and 2 direct care workers were working on shifts."	

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V 296	Continued From page 4 him. . . Authorities contacted . . . [local police department] . . . " During interview on 6/15/20 FC #1's Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator stated FC #1 was found in a neighboring state. Review on 6/15/20 of FC #2's record revealed: - 16 year old male. - Admission date 3/17/20; discharge date 5/05/20. - Diagnoses included Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder (PTSD), and "Intellectual Disability Disorder." - "Comprehensive Clinical Assessment" dated 3/17/20 included ". . . Presenting Problem: . . . residing in Level III care since transitioning from . . . detention after having legal challenges stemming from felony larceny and other charges including grand theft auto . . . Present Condition/Psychiatric Treatment History . . . Community Violence . . . Trauma/PTSD Symptoms: . . . Self-Destructive Behavior . . . Reckless Behaviors. . . Oppositional Symptoms: . . . Often Loses Temper . . . Argues (with) Authority Figures . . . Conduct/Anti-Social Symptoms: . . . Destroyed Property . . . Has Stolen . . . Runs Away . . . Initiates Physical Fights . . . " - "Person Centered Profile" completed 1/07/20 and updated 5/05/20 included ". . . Where am I now in the process of achieving this outcome? . . . 4-20-20: . . . The team has met and agreed that consumer will need a higher level of care due to not being able to secure him and keep in safe . . . Consumer has AWOL several times since the last review (3/24/20) . . . will be search for contrabands by staff; . . . 3-24-20 . . .has AWOL	V 296		

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since coming into placement and gotten to an altercation at a party when he AWOL which some boys came to group home looking for him twice . . . 4-20-20 . . . Team has agreed that he needs to step up to higher level of care for safety issues. He has AWOL 2 more times and got hurt and required medical attention on 3-30-20 . . . "
- "Safety Assessment Plan" dated 3/23/20 included " . . . [FC #2] will create an environment that reduces anxiety and Promote Safety by: (a) Intensive Supervision at all times (b) Keep a visual at all times (c) Managers to work weekends (d) Managers to do one on one time to identify issue that are occurring to find out the issue for eloping . . . (f) Change up the staffing and change shift . . . "
- "Service Note" signed by the Director/Associate Professional (AP)/Licensee and dated 5/2/20 included " . . . Shift/Duration of Service: . . . 11pm - 7 am . . . Intervention Activity (What you did) Staff processed with consumer about his behaviors and why he was up so late at night. Staff processed with consumer about the importance of attending school and trying to achieve his goals. Staff processed with consumer that he needs to focus on getting out of the group home and not continuing to destroy property and vandalize property. Staff processed with consumer about arguing with her about his phone and money that his mother sent to him through mail. Staff re-directed consumer about language and directed him to go to his room and prepare for bed. Staff observed the consumer to go to his room and continued to come out arguing with staff and stating he was going to leave the home. Staff directed consumer to reframe from his behaviors and warned consumer not to leave the home. Staff processed with consumer that he needed to stay at the home Because of the covid-19. Staff observed consumer to come out

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V 296	Continued From page 6 of his room with a book bag and re-directed him to go back to his room. Staff observed consumer to try to get out the back door and he jammed the door on the roller. Staff re-directed the consumer to stop and not go out the door. Staff observed consumer to run down the street. Staff got in the car and tried to find the consumer. Staff could not locate the consumer and returned back to the home and called police to complete a report. . . . Effectiveness of the Intervention Activity . . . consumer was curing at staff and his peers throwing objects in his room and threatening that he was leaving the home . . . Consumer came out his room with his book bag and cursed staff out as she tried to block him from leaving out the door. Consumer tried to force the back door open and broke the door off the track on the roller. Consumer then ran to the front door and left the home. Consumer ran down the street as staff got into the car and came to look for him. Consumer did not return back to the home before the shift ended. Consumer was reported on run away status." - No documentation FC #2 returned to the facility after eloping 5/02/20. - MAR for May 2020 included transcribed entries for lithium carbonate (can be used to treat manic episodes of bipolar disorder) 300 mg w tablet twice daily, quetiapine (antipsychotic) 400 mg 1 tablet at bedtime, and hydroxyzine (can be used to treat anxiety) 50 mg 1 capsule at bedtime. Review on 6/01/20 of NC IRIS incident reports 4/28/20 - 6/01/20 for FC #2 for "Unplanned consumer absence of more than 3 hours or that requires police contact" revealed: - "Level II incident report . . . Date of Incident: 5/2/2020 Time of Incident: 1:30 am . . . of ". . . Unplanned consumer absence . . . that requires police contact.. . "	V 296		

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V 296	Continued From page 7 - - ". . . Authorities contacted . . . [local police department] . . . " - "Supervisor Actions: . . . Describe the cause of this incident: 5/4/2020 consumer was ask by staff to go to bed. He was refusing and being non-compliant. He kept coming out his room but staff was in the hallway. He started getting in staff face daring him to move him and stop him from leaving. This went on for 45 minutes. Consumer yelled at other consumer get your stuff were going to be out of here. Consumer said man I can push you down and nothing will be done because as you see police will come but you can't press charges on me. Consumer push staff out the way and took off on foot. Other staff ran behind him until he split up with other consumer and he went over the fence with dog and into the woods. . . . " - Level II incident report ". . . Date of Incident: 4/28/20 Time of Incident: 12:30 am . . . of ". . . Unplanned consumer absence . . . that requires police contact.. . " - ". . . Authorities contacted . . . [local police department] . . . " - "Supervisor Actions: . . . Describe the cause of this incident: 4/28/20 . . . Consumer became verbal aggressive. When he found out the AP [Director/AP/Licensee] was working shift he became explosive . . . He started communicating threats to her trying to break in her car and jumping on her car . . . he started communicating threats to bodily harm and property damage. . . Staff switch shift and he calmed down. . . Upon doing room check with 8 minutes he busted the alarm on his window and went out the back. Staff went around the house and over the fence to go after him but is was pitch black and lost sight of him. . . . " During interview on 6/15/20 FC #2's LME/MCO	V 296		

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V 296	Continued From page 8 Care Coordinator stated FC #2's whereabouts were unknown. Review on 6/15/20 of FC #4's record revealed: - 16 year old male. - Admission date 5/22/20; discharge date 6/03/20. - Diagnoses include: Oppositional Defiant Disorder and Post Traumatic Stress Disorder. "GAIN-I (Global Appraisal of Individual Needs) Recommendation and Referral Summary" dated 10/09/19 and updated 5/13/20 included history of "anger, gang involvement, marijuana use, disrespect, running away, criminal activity and stealing. . . Mom kicked [FC #4] out of the house . . . after he had gang members and her home and stole from her. Mom reports [FC #4] has had two vehicles and currently drives a BMW. She is unaware of how he gets the cars . . . concerned that he could injure someone due to him not having a license or insurance. He steals license plates off other vehicles to put on the ones he drives. . . Addendum 5/13/20 . . . [FC #4] has been placed in the custody of the Department of Social Services (DSS) . . . DSS staff reports that his mother witnessed him on one occasion come home "flashing thousands of dollars. Per DSS, [FC #4] was labeled as runaway status from 4/7 - 4/9 and again on 4/17. On 5/11, DSS states [FC #4] was apprehended by (local Sheriff's Department) on a report of alleged larceny of a vehicle. . . [FC #4] received a CALOCUS (Child and Adolescent Level Of Care Utilization System) of 25 supporting a referral for a level 3 residential placement. [FC #4]'s high-risk behaviors independently support the need for a higher level of care . . . " - "Discharge Planning/Summary Form" dated 6/03/20 included " . . . Unplanned Discharge . . . Presenting Condition . . . gang affiliation, driving stolen cars, substance abuse, legal issues,	V 296		

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non-compliant, verbal/physical aggressive, want follow rules, runaway . . . Status of the client at discharge: [FC #4] was fine when he left the house . . . Recommendations for Services or Supports: [FC #4] needs to be in a PRTF (Psychiatric Residential Treatment Facility) to provide more secure measures since this was his first placement. . . "
- "Person Centered Profile" completed 5/22/20 and updated 6/3/20 included " . . . Action Plan . . . Where am I now in the process of achieving this outcome? . . . 5-22-20 . . . Mom stated that he is driving a BMW which isn't hers nor his and didn't want divulge, has stolen license plates off vehicles so he can drive the car he has at the time. He will not comply to any of her rules in the home, very disrespectful he stays out late, he displays verbal/physical aggrressions when he becomes angry. Consumer has had legal issues in the past, gang involvement, substance abuse, running away, criminal activity, stealing and some school suspensions . . . 6-3-20 Discharged to elopement. . . "
- "Service Note" dated 5/29/20 and signed by Staff/AP #1 included " . . . Intervention Activity . . . Staff pointed out to him that running isn't the answered. . . Staff tried to get the consumer to come in the home but he kept refusing. Staff asked him to at least let's go sit on the porch and get out the rain. . . Staff and his peer tried to calm him as he was becoming more aggressive outside and refusing to come back in the house. Staff just continues to monitor him and keeping a visual on him as he was walking in the cul-de sac as night was drawing. Staff keeps trying to process with him. Staff tried to get him to do self-calming techniques before he took off down the street when the rain started pouring down really hard. Staff wasn't able to find him due him jumping over the fence into a wooded area

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management she said would look and to head him off. QP (Qualified Professional) did the report once she report came back the home. Staff had no contact with consumer on this shift. Effectiveness of Intervention Activity Consumer was sitting on the porch when shift arrived on shift. . . . he can care less about trouble he just wants to be out of here. . . . got up and walked to the mail box. But he did come back and sat down on the steps again. He stated that he isn't going back in the house at all. Consumer stated you can't make me do anything. Consumer kept making his way to the stop sign refusing staff directives at this point. Consumer was getting louder and aggressive as if him wanting to create a show or diversion. . . Consumer finally had enough and once the rain had started pouring he just took off down the street and over the fence into the wooded area. Consumer had no more contact with staff on this shift. . . "
- Service note signed by the QP and dated 5/28/20 included " . . . QP called DSS worker to inform her that she thinks that we need to have a txt mtg (treatment team meeting) to discuss a higher level of care for consumer. QP explained to her that he needs to be in a more secure placement because he is going to elope if he gets the chance no matter how hard we try to process with him. . . QP expresses to her that she just wants to do something now before he does something. DSS worker stated that if he does run away just for us to do a report and notify them. . . "
- No documentation FC #4 returned to the facility after eloping 5/29/20.

Review on 6/17/20 of a "Fax Tranmission Sheet" from the QP revealed "No (safety) assessment was done on [FC #4] because he was only there for 6 day. He only ran away once which was the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	Continued From page 11 day he left. He just talked about it." Review on 6/01/20 of NC IRIS incident reports 4/28/20 - 6/01/20 for FC #4 for "Unplanned consumer absence of more than 3 hours or that requires police contact" revealed: - Level II incident report ". . . Date of Incident: 5/29/20 Time of Incident: 8:40 pm of ". . . Unplanned consumer absence . . . that requires police contact.. . . Supervisor Actions . . . Describe the cause of this incident: . . . Since consumer arrival he continues to let everyone know that he was going to AWOL (Absent Without Leave). Consumer and staff were all sitting on the porch because consumer was refusing to go in the house. . . . Consumer started getting loud and displaying verbal aggressions towards staff. The second staff tried to process with him as well . . . Consumer took off down the street, cut through neighbors yard and over the fence. Staff lost visual due to the rain coming harder at this point. AP called the police to make a report. . . Incident Prevention: 6/1/2020 He hasn't been found as of today. However, the DSS worker stated that she believes he is back in (a nearby city) with his old gang member . . . " During interview on 6/16/20 FC #4's DSS caseworker stated she believed FC #4 was somewhere in (a nearby city), but she didn't know where. Prior to his admission to the facility, DSS completed and submitted an "intake package" for the facility that included copies of his assessments that detailed his history, behaviors and supervision needs. FC #4 had known street gang affiliation and the Department of Juvenile Justice was involved in his care. Review on 6/17/20 of Staff/AP #1's personnel record revealed:	V 296		

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V 296	Continued From page 12 - Hire date 4/30/07, title of Associate Professional. - Training in NCI+ (National Crisis Interventions) dated 4/20/20; "Restrictive Techniques Score Sheet" with "Wrap" and "Limited Control Walk" the only interventions checked on the score sheet. - Training in "Juvenile Sex Offender Training" dated 2/15/20. During interview on 6/17/20 Staff/AP #1 stated: - He worked first and second shifts at the facility. - Although he was an AP, he also worked as a direct care provider. - There were always two staff on shift. - On 5/29/20 he arrived on shift and found FC #4 outside with FC #3 and staff #3; FC #4 was agitated and did not want to go inside the house. - He attempted to "process" with FC #4 and to de-escalate the situation, but FC #4 left. - He looked for FC #4 for "about an hour" and returned to the facility. - He called the police when he returned to the facility. - He was trained in crisis response. Review on 6/17/20 of staff #2's personnel record revealed: - Hire date 3/12/18, title Direct Care Provider. - Training in NCI+ (National Crisis Interventions), "Restrictive Techniques Score Sheet" with "Wrap" and "Limited Control Walk" the only interventions checked on the score sheet.. - Training in "Crisis De-Escalation, Crisis Plan, Crisis Prevention and Response" dated 2/08/20. - Training in "Juvenile Sex Offender Training" dated 2/15/20. During interview on 6/17/20 staff #2 stated: - He usually worked the first shift at the facility.	V 296		

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V 296	Continued From page 13 - He had received training in the clinical histories of the clients and in their person centered plans. - There were always 2 staff present on shift. - He was not on shift when the clients eloped. - If a client was agitated and threatening to run away, he would attempt to redirect and de-escalate the situation. - If the client ran away, he would not follow the client; he would wait 10 - 15 minutes to see if the client returned; if the client didn't return he would call the police. Review on 6/17/20 of staff #3's personnel record revealed: - Hire date 5/03/11, title Direct Care Provider. - Training in NCI+ (National Crisis Interventions), Restrictive dated 4/21/20; "Restrictive Techniques Score Sheet" with "Wrap" and "Limited Control Walk" the only interventions checked on the score sheet. - Training in "Crisis De-Escalation, Crisis Plan, Crisis Prevention and Response" dated 2/08/20. - Training in "Behavior Management/Management of Aggressive Behavior/Incident Reporting/Critical Incident Reporting" dated 2/08/20. - Training in "Juvenile Sex Offender Training" dated 2/15/20. During interview on 6/17/20 staff #3 stated: - She worked as a "Direct Care Giver" on all three shifts at the facility. - One of her responsibilities was to "review the service plan with the consumers" with "focus on the goals and behaviors." - There were always usually 2 staff on shift; management staff sometimes worked on shift. - Clients had eloped while she was on duty but she preferred not to share their identities. - When a client became agitated, "we try to process with them. We can't put our hands on	V 296		

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them."
- If a client talked about eloping, she would "process with them first and try to stop them."
- Staff would "block the door" by standing in front of it to prevent the client from leaving the facility.
- If the client eloped, she called the police and searched the area for the client; one staff would search for the client while the other staff stayed at the facility with the other clients.
- "Sometimes they come back on their own."
- All of the windows and doors had alarms.

During interviews on 6/04/20, 6/17/20 and 6/19/20 the Qualified Professional stated:
- There were no clients at the facility at the onset of the survey; new clients would be admitted but management wanted to ensure "some issues are addressed first."
- There were usually 2 staff on shift at the facility, sometimes there were 3 staff on shift; there were always 2 staff on overnight shift with one stationed in the hallway to monitor client bedrooms.
- FC #1 and FC #2 eloped 5/03/20 and FC #4 eloped 5/29/20.
- FC #1 went "AWOL" 5/03/20 and was found in a neighboring state; he was scheduled to be discharged from the facility on his 18th birthday 3 days after he eloped.
- To her knowledge FC #2 and FC #4 had not been found.

During interview on 6/19/20 the Director/AP/Licensee stated:
- Clients admitted to the facility had extreme behaviors and often had no other placement options.
- The staffing pattern at the facility was revised following the last survey (4/28/20) to include management staff working on shift as needed to

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provide supervision for the clients.
- There were often 3 staff on shift, 2 direct care staff and a member of the management team.
- Staff attempted to block the doors if a client tried to elope, but staff did not perform restrictive interventions.
- A staff person was stationed in the hallway at night to monitor client bedrooms and client movements.
- She contacted the LME/MCO and Department of Social Services seeking advice and technical assistance.
- She did not know what else she could do to ensure supervision of the clients or to prevent elopements.

Review on 6/24/20 of the Plan of Protection completed by the Director/AP/Licensee dated 6/24/20 revealed:
- "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? (SEE ATTACHMENT PAGE 1)."
- "Describe your plans to make sure the above happens. (SEE ATTACHMENT PAGE 2)."
- "Plan of Protection The Behavioral concerns were addressed during a Management Meeting, all the Behavior Data was discussed to include: elopement, physical and verbal aggression, property damage, non-compliance with the rules, and gang activity, etc. The Sleep Charts were reviewed to determine the timeframe the consumers were awake with disrupted behaviors, the shifts that the behaviors occurred on and the staff that was working the shifts. As I stated in my previous Plan of Correction in April 2020 and my exit interview on June 19, 2020; additional staff were put on the shifts during those time frames to reduce the behaviors. I increased my staff with [the AP] QP. I increased additional work hours

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for the Shift Leader [Shift Leader] and [the QP]. I also worked additional hours to have a manager on shifts during the behaviors time frames. Therefore, I had 2 direct care workers and 1 manager on shifts during the behaviors time frames. The staff attempted to processed with the consumers to de-escalate the behaviors and encouraged the consumers to use their coping skills. Staff utilized the crisis plan techniques for de-escalation of the consumers. I purchased new games and activities to reduce the boredom and restlessness during the covid-19 stay at home order. Emergency Team Meetings were scheduled to discuss the behavior problems and discharge to a higher level of care. We are in the middle of a Pandemic; therefore new admissions to other facility were limited and another obstacle was the consumers did not meet criteria for the placement since it was willful behaviors."
- "Linked to Outside Resources The consumer Therapists were contacted for tele-therapy. The Care Coordinators were involved with providing input and assisting with contacting other facilities for lateral placements and higher level of care facilities. The Parents/Guardians refused to allow the consumers to be discharged to their homes. Therefore, two CPS (Child Protective Services) reports for abandonment was completed with the [local Department of Social Services]. The [local Department of Social Services] refused to take the consumers into custody because of the Pandemic Covid-19 virus the department was only taking emergency placement. The [local Police Department] was contacted for the property damage and reports were completed. However, we were unable to bring charges against the consumers for the property damage because of the Covid-19 Virus. We were informed by [Police Detective] that a report would be taken and we would be contacted at a later

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date to be informed if charges will be made against the consumer and given a court date. The [LME/MCO Care Coordinator] was contacted for safety advice to obtain a secure order for the consumers and she advised me to contact the DJJ (Department of Juvenile Justice) Court Counselor. I contacted the Court Counselor and she informed me that secure orders were only being given for major criminal charges suchas; homicide, assault with a deadly weapon, arm robbery were being incarnated because they were trying to discharge the juveniles due to the Covid-19 Virus. The Magistrate was contacted to request a IVC (involuntary commitment) to the hospital. However, it was denied because she felt it was just willful behaviors."
- "Implementation of Plan My plan to protect the clients from risk or harm will be to continue the plan I have utilized with staffing of two direct care workers on shift. I will continue to assess the behaviors and bring in additional staff if they are needed to reduce the behaviors and secure the clients. I revised my discharge policy to "immediate" discharge if the consumer elope from the facility. The management team will spend more time assessing clients before admission to ensure we are more aware of the consumers that were in an institution during the same time frames. The four consumers we previous had already knew each other from being in other placements together. One of the consumers previously lived in the neighborhood with a foster parent and he continued to elope because he went to her home and he had friends in the area that were members of a gang. A Universal Admission form was created to be completed prior to admission to gather more information about the client history and prior placements. Prior to admission to the facility the management team will try to gather data on

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previous placements and the geographic areas. The management team will also try to implement a telephone interview with the client. The alarms on the windows and doors will continue to be utilized. The alarm monitoring system on the outside of the home will continue to be utilized. Staff will continue to sit in the hall way to monitor clients during sleep hours. Staff will continue to keep a visual on the consumers during awake hours. The Management will continue to monitor the facility to ensure the staff is awake and present on shift with no problems. I will continue to provide training for the staff in areas of de-escalation of behaviors and prevention of a crisis. Staff completed a training in April on NCI de-escalation and prevention. I will train the staff on gang awareness and try to conduct research on gangs in the geographic area of the facility and school. The Board of Directors met to discuss the property damage, admission criteria, discharge criteria and staffing of the facility. The Clients Rights committee met to discuss the possibility of implementing cameras outside the facility and the violation of client or staff rights to being recorded. The use of the camera to capture property damage, gang activity, and if the clients activity/recreation time outside is a disturbance to the neighbors."

This deficiency was cited as a standard deficiency during the survey completed 4/28/20, but evidence in this survey has increased the severity of this deficiency.

Former clients #1, #2, and #4 had diagnoses that included Conduct Disorder, Intermittent Explosive Disorder, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder and Intellectual Disability. Each

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client was prescribed psychotropic medications. Former clients #1, #2, and #4 had well documented histories of elopement, serious criminal behaviors which included felony larceny and grand theft auto. Former client #1 had a known history of inappropriate sexual contact with younger peers. Former client #4 had a confirmed gang affiliation and a known history of substance abuse. According to the "Safety Assessment" plans for former clients #1 and #2 each required intensive supervision at all times to prevent elopement; former client #4 did not have a Safety Assessment completed at admission. Per interview the facility's staffing pattern was two paraprofessionals, with management staff periodically working on shift to help de-escalate behaviors. Prior survey dated 4/28/20 revealed inadequate staffing in the facility. In the Plan of Correction completed and signed on 5/13/20, the Licensee agreed to have the AP and QP provide individualized supervision by increasing staff on each shift to assist with the clients' disruptive behaviors. Despite management staff working on shift, former clients #1, #2, and #4 eloped from the facility (client #1 on 5/03/20, client #2 on 5/02/20 and client #4 on 5/29/20). Former client #4 had been at the facility for only one week prior to his elopement. At the time of this survey, the whereabouts of former clients #2 and #4 remained unknown.
The facility's failure to ensure more than minimum required staffing based on individual client needs as specified in assessments and treatment plan and to prevent continued elopements from the facility constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be

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V 296	Continued From page 20 imposed for each day the facility is out of compliance beyond the 23rd day.	V 296		